Government of the District of Columbia
Anthony A. Williams, Mayor

DEPARTMENT OF HEALTH

INFORMATION FOR THE MEDICAL COMMUNITY AND THE PUBLIC FROM THE

D.C. BOARD OF MEDICINE

October 2003

INTERNET LICENSE LOOK UP

If you want to check the license status of a physician or other health professional in the District of Columbia, you can get that information from the Internet. Go to www.dchealth.dc.gov and click on "Professional Licensing." Then click on "Online Professional License Search." The database reflected at that site is a web-adapted, real-time version of the internal Department of Health database. If you do not have access to the Internet, the license status of health professionals can be obtained through (202) 442-9200.

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"OLD AGE" AS A CAUSE OF DEATH

The following article is presented for public information and to stimulate discussion in the medical community:

From the *Pittsburgh Post-Gazette:*

HEALTH OFFICIALS LOATH TO ACCEPT OLD AGE AS CAUSE OF DEATH 'EVERYBODY DIES OF SOME DISEASE'

BYLINE: GARY ROTSTEIN, POST-GAZETTE STAFF WRITER

Strom Thurmond and Katharine Hepburn shared little in life other than celebrity status, but their deaths bonded them in an unusual way.

No one spoke of heart attack, stroke, cardiovascular disease, pneumonia or any other specific cause of death when the right-wing South Carolina senator and liberal Yankee actress died in late June, he at 100 and she at 96.

It was simply, in the words of the obituaries three days apart, "old age." Weeks before them, actor Gregory Peck's demise at 87 was described the same way.

It was their time. It was natural. Their bodies wore down. They gave out or failed to thrive. They had what geriatricians sometimes refer to with a quiet shake of the head as "the dwindles."

The government's health officials and statisticians don't accept old age on death certificates, however, and you can sure bet they don't like the dwindles any better. They don't even want to see more formal-sounding synonyms such as "senescence" or "multifactoral frailty."

The National Center for Health Statistics and state health departments want a specific cause of death, whether you live 100 days or 100 years. That policy no longer made sense to Thurmond's physician, Dr. Ned Nicholson, of Edgefield, S.C., when the centenarian died.

With some measure of satisfaction, Nicholson put "old age due to multiorgan failure" on the death certificate. He'd never used the description before in his 40 years of practicing medicine, but felt it accurate and appropriate.

What's more, he felt it would stick, given the senator's prominence.

"When he started declining, it just went rapidly, but there wasn't any specific event like a heart attack or stroke," Nicholson said of Thurmond, who was active well into his 90s. He spent his last six months in a hospital, alert but weakening after leaving office in January.

"Certainly, I've had other remarkable individuals die similarly, and I've always chafed a little bit at the way the bureau of statistics wants us to put a cause," Nicholson said. "I thought this was the perfect chance to challenge that. And they have not returned the death certificate to me ... as of now."

The 113 cause-of-death classifications used by the National Center for Health Statistics, a condensed version of the 8,000 causes acknowledged by the World Health Organization, don't allow for any such "old age" foolishness.

Thurmond's certificate will go under a catch-all category for natural causes, respiratory failure, cardiac arrest, asphyxia, senility – all lumped as "symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified."

About 26,000 of the nation's 2.4 million annual deaths in 1999 fell into the symptoms, signs and so-on realm, a mere grain in the valley of death compared to heart disease and cancer, which jointly take credit for more than half of U.S. mortality.

The symptoms, signs category is one so general that state officials often query the physician about the death so a specific cause can be assigned. More than one-fourth of the deaths preliminarily placed in the symptoms signs classification in 1998 were subsequently moved after official questioning.

"If you think about it from a public health standpoint, everybody dies of some kind of disease," and it's important to know which ones for funding and research purposes, said Robert Anderson, chief of the mortality statistics branch within NCHS and the Centers for Disease Control.

Death may occur "because their body is wearing out, but there's still a disease of the kidneys, or a disease of the heart. Old age just doesn't tell us what was affected."

Death certificates have space for physicians to put an "underlying" cause of death, considered the true cause, and several secondary causes which contribute. Anderson said he doesn't mind if age is cited as a secondary cause; it's the underlying cause, however, that makes its way into official statistics.

The certificate data is questionable regardless of the old-age issue, because studies comparing physicians' judgments and the more rigorous autopsies that sometimes follow find doctors err as much as 30 percent to 40 percent of the time.

Dr. Eric Rodriguez, medical director of UPMC's Benedum Geriatric Center, said such assessments are more difficult with older patients than younger. When in doubt, he'll usually settle on coronary artery disease for the government's sake, but not with any confidence.

"Very often it's a best guess. ... I'm thinking the reality is this person died of old age," said Rodriguez, who averages writing about one death certificate a week.

"All the processes of aging that occur below the clinical radar screen add up to confer a degree of frailty on the person, so that something that would not harm them earlier becomes lethal," he said, such as pneumonia or other infections.

Leonard Hayflick, an anatomy professor at the University of California, San Francisco, who has done pioneering research on cell aging, compared it to the wear and tear on an automobile once it's driven from the showroom.

"There are weak links, and the weak links begin to break, and many begin to break in a relatively narrow point of time," Hayflick said.

"The molecules that make up the major systems and minor systems in an auto eventually fail due to rust, corrosion and interaction with other chemicals. In humans, there is a decrease in the

physiological capacity in organs, and the organ most vulnerable is the one for which the cause of death is the greatest -- the cardiovascular system."

Hayflick said humans essentially are lucky for any years beyond 20, because nature established two decades as the necessary life span to assure procreation and continuation of the species. "No one has ever found the remains of ancient humans older than about 40 or 50," he said.

Today, there's no agreement at when old age sets in, since everyone ages differently based on their genetics, health habits and environmental factors.

Rodriguez said some doctors view the 80s as the age when people begin "living on borrowed time," but he doesn't view it that way until people turn 90 -- and even then there are exceptions.

Allegheny County Coroner Dr. Cyril H. Wecht said he can't accept the notion of old age as a cause of death, and none of the 2,000-plus certificates leaving his office annually list anything of the kind.

"Sure, there's old age, but you don't die because you reach a certain birthday," Wecht said of such cases. "The answer usually is that on the day they died, their heart simply began to beat irregularly," he said of the oldest patients. "Most of the time, if doctors put down cardiovascular disease, they're going to be right. They will be right nine times out of 10."

Dr. G. Alan Yeasted, vice president of medical affairs at St. Clair Hospital, said most doctors do pretty much what Wecht advises, if they have uncertainty. A lot of people, it seems, die of broken hearts.

"We would generally put down the heart as a cause, unless you know the cause," said Yeasted, president of the Allegheny County Medical Society. "If you put down cardiac failure, you don't get a call" from anyone questioning it.

It's unclear just how much families and the public thirst for knowledge of anything more specific about late-life deaths, particularly when talking about deceased individuals approaching 90 and beyond.

Some doctors say people have become more scientifically savvy and want to know about the demise in precise terms. Others have talked to families who appreciated the chance to think of their relatives' passing in the more restful "it was their time" mode, with everything in mom's or grandpa's life having been accomplished.

The latter viewpoint is what health officials believe colors the obituaries of Hollywood icons, leading publicists to disseminate a more idyllic-sounding end for a Hepburn or Peck than whatever's on the death certificate.

Descriptions of death will merit more debate as the nation's elderly population doubles over the next 30 years, noted Dr. Joanne Lynn, a geriatrician heading the Washington Home Center for Palliative Care Studies in Washington, D.C. She said the government's obsession with identifying a cause of death made more sense in the last century, when eradicating a fatal disease such as polio added many decades of life.

"Now the usual person has multiple illnesses and very little physical reserve at the time they're dying," Lynn said, so the value in knowing any specific cause is diminished.

"If you stop all heart disease in the Medicare population, you would get a very small prolongation of life, on average just a year or two, and greatly increased odds then of dying of strokes or dementia," said Lynn, a fan of the "multifactoral frailty" term for nonspecific, late-life deaths.

As for Nicholson, he'll stick with "old age." He's open to citing it again should another fatal South Carolina candidate come his way. "I'm looking for the next case to do it," he drawled. "I think it's more accurate than trumping up the diagnosis."

Accredited and anonymous comments are invited regarding the above article.

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BOARD ORDERS

July-September 2003

Revoked:

Gonzalez, Ramon L.: (7/9/03). The physician's D.C. medical license was revoked. The physician was disciplined in Maryland for actions that would be grounds for disciplinary action in D.C., including filing a false application with the Board, violation of a disposition agreement that required abstinence from alcohol and narcotics, failure to maintain adequate records and sexual boundary violations.

Stein, Martin H.: (7/9/03) The physician's D.C. medical license was revoked. The physician surrendered his Virginia license in view of charges of inappropriate prescribing and monitoring, boundary issues and other quality of care concerns.

Fernbach, Louise O.: (7/9/03) The physician's D.C. medical license was revoked. The physician surrendered her Virginia license as a result of prescription irregularities.

Hodjati, Hassan: (9/22/03) The physician's D.C. medical license was revoked. The physician wrote hundreds of prescriptions for narcotics for personal consumption; is habitually addicted to or habitually used a narcotic or controlled substance; fraudulently or deceptively used a medical license; prescribed, dispensed or administered drugs when not authorized to do so; and his Maryland license was summarily suspended.

Summarily Suspended:

Anderson, Kimberly A.: (9/2/03) The physician's D.C. medical license was summarily suspended as a result of a determination that she represents an imminent threat to public health and safety as a result of relapsed substance abuse.

Afolabi-Brown, Richard: (9/11/03) The physician assistant's D.C. license was summarily suspended as a result of a determination that he represents an imminent threat to public health and safety as a result of sexual harassment of a patient or patients; using the term, "M.D.," with the intent of representing himself as practicing medicine when he was not authorized to do so; represented to the public by title, description of services, methods or procedures that he was authorized to practice medicine in the District of Columbia; and failed to register a job-description with the Board of Medicine, which is required to perform as a physician assistant.

Suspended:

Berner, Todd P.: (7/24/03) The physician's D.C. medical license was suspended until such time as he has an unencumbered license to practice medicine in Virginia. The physician was disciplined in Virginia for conduct that would be grounds for disciplinary action in D.C. He engaged in inappropriate touching of a patient manifesting failure to conform to standards of acceptable conduct and prevailing practice within a health profession and demonstrating willful and careless disregard for the health welfare or safety of a patient.

Fined:

Nguyen, Dianne H.: (7/31/03) Fined $2000 by consent order. The physician was disciplined in North Carolina for actions that would be grounds for disciplinary action in D.C., prescribing without seeing a patient.

Cooper, Wayne D.: (9/24/03) Fined $300 by consent order. The physician paid or agreed to pay a fee for professional services for the referral of patients.

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The D.C. Board of Medicine

The current members of the Board are:
William E. Matory, M.D., Physician Member and Chairperson;
James A. Buford, M.P.H., Statutory Member;
Frederick C. Finelli, M.D., Physician Member;
Jean A. Linzau, M.D., Physician Member
Lawrence A. Manning, M.D., Physician Member;
Morton J. Roberts, M.D., Physician Member;
Peter G. Shields, M.D., Physician Member;
Ronald Simmons, Ph.D., Consumer Member;
Andrea D. Sullivan, N.D., Ph.D., Consumer Member; and
James A. Towns, Esq., Consumer Member.

The Board staff includes **Mr. James R. Granger, Jr.**, Executive Director, and **Ms. Antoinette Stokes**, Health Licensing Specialist. The Board's phone number is (202) 442-9200. The fax number is (202) 442-9431.

CONTINUING MEDICAL EDUCATION FOR NON-PRACTICING PHSYICIANS

The last renewal cycle for physicians revealed that many licensees were unaware of the requirement for continuing medical education (CME) for non-practicing physicians. Although under consideration for future implementation, at the present time there are no CME requirements for licensure renewal for D.C. practicing physicians. There is, however, a requirement for non-practicing physicians to document CME for renewal. If a non-practicing physician does not complete the required CME, the physician or the Board may place the license on paid inactive status. The physician may return to active status upon the Board's acceptance of documentation of the required CME. While on inactive status, a physician cannot practice. A licensee may remain on inactive status indefinitely, but will not be required to pay additional renewal fees or file a renewal form until such time as he or she returns to active status. The regulations, from 17 DCMR §4606 and §4607 are shown below.

4606 CONTINUING EDUCATION REQUIREMENTS FOR NONPRACTICING PHYSICIANS

4606.1 This section shall apply to the renewal of a license, the reactivation of the license of a physician in inactive status, or reinstatement of an expired license of an applicant who is not actively practicing medicine.

4606.2 For purposes of this section, subject to the Board's discretion, a physician whose practice does not meet the requirements of § 4606.3 shall not be considered to be actively practicing medicine.

4606.3 For purposes of this section, a physician is actively practicing medicine, if each calendar year, the physician meets the following requirements:

(a) Maintains a practice of one thousand (1,000) patient-visits per year;
(b) Is employed full-time in medical teaching, research, or administration; or
(c) Is employed part-time in medical teaching, research, or administration and maintains a practice of five hundred (500) patient-visits per year.

4606.4 An applicant for renewal, reactivation, or reinstatement of a license who has not been actively practicing medicine for a period of one (1) to five (5) years shall submit proof under § 4606.7 that the applicant has completed acceptable continuing medical education for each year after December 31, 1988, that the applicant has not been actively practicing medicine as follows:

(a) Twenty-five (25) hours of credit in continuing medical education meeting the requirements of Category 1;
(b) Twenty-five (25) hours of credit in continuing medical education meeting the requirements of either Category 1 or Category 2.

4606.5 An applicant for reactivation of an inactive license who has not been actively practicing medicine for five (5) or more years after December 31, 1988, shall submit proof under § 4606.7 that the applicant has completed, during a two-year (2) period immediately preceding the date of application, acceptable continuing medical education as follows:

(a) One (1) year of clinical training in a program accredited by the ACGME or the AOA; or
(b) The following:
  (1) One hundred fifty (150) hours of credit in continuing medical education meeting the requirements of Category 1; and
  (2) One hundred fifty (150) hours of credit in continuing medical education meeting the requirements of either Category 1 or Category 2.

4606.6 After December 31, 1990, a physician whose license has been expired for five (5) or more years shall meet the requirements for obtaining an initial license under this chapter and the Act.

4606.7 An applicant under this section shall prove completion of required continuing education credits by submitting with the application the following information:

(a) For claims for Category 1 credit:
(1) The name of the program, its location, a description of the subject matter covered;
(2) The dates on which the applicant attended the program;
(3) The hours of credit claimed; and
(4) Verification by the sponsor of completion, by signature or stamp.
(b) For claims for Category 2 credit;
(1) A description of the program or activity;
(2) The dates on which the applicant attended the program or activity;
(3) The location of the program or activity;
(4) The hours of credit claimed; and
(5) Verification by the applicant of attendance.

4607 APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES

4607.1 The Board may, in its discretion, approve continuing education programs and activities that contribute to the knowledge, skills, and professional performance and relationships that a physician uses to provide services to patients, the public or the profession and which meet the other requirements of this section.

4607.2 To be acceptable for credit, a continuing medical education program or activity shall be limited in content to that body of knowledge and skills generally recognized and accepted by the medical profession as within the basic medical sciences, the discipline of clinical medicine, or the provision of health care to the public.

4607.3 The Board may approve continuing education programs and activities for Category 1 credit which meet the following requirements:

(a) Meet the requirements of §§ 4607.1 and 4607.2;
(b) Are sponsored or co-sponsored by:
(1) The Accreditation Council for Continuing Medical Education (ACCME); or
(2) A state medical society; and
(c) Are designated as American Medical Association Physician's Recognition Award (AMA/PRA) Category 1 programs by the sponsoring organization.

4607.4 The Board may approve continuing medical programs and activities for Category 2 credit which meet the following requirements:

(a) Meet the requirements of §§4607.1 and 4607.2;
(b) Consist of one (1) of the following activities:
(1) Grand rounds;
(2) Teaching rounds;
(3) Seminar;
(4) Lecture;
(5) Medical teaching;
(6) Patient care review;
(7) Publication or presentation of an article related to medicine;
(8) Mini-residency;
(9) Workshop;
(10) Course of instruction; or
(11) Reading medical literature; and
(c) Are prepared, sponsored, or administered by:
(1) The ACCME;
(2) A state medical society;
(3) A governmental unit;
(4) A licensed hospital;
(5) An institution or higher learning recognized by an accrediting body approved by the United States Secretary of the Department of Education; or
(6) A journal published primarily for readership by physicians.

4607.5 An applicant shall have the burden of verifying whether a program is approved by the Board pursuant to this section prior to attending the program. The applicant shall also have the burden of verifying the number of continuing education credits the Board will accept for a program under this section.

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Please address comments or suggestions for future newsletters to:

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